STATE COUNCIL ON DEVELOPMENTAL DISABILITIES

ROUTING INSTRUCTIONS:
Complete five copies to be distributed as follows:

SUPPORT SERVICES EXPENSE CLAIM

Copy 1, 2, 3 To accounting Systems Bureau
Copy 4 To Provider
Copy 5 To Employee

MEMBER'S NAME		SOCIAL SECURITY NUMBER	
RESIDENCE ADDRESS (STREET NUMBER, CITY, STATE AND ZIP CODE)			
DEPARTMENT STATE COUNCIL ON DEVELOPMENTAL DIS.	DIVISION OR BUREAU Headquarters	TELEPHONE (916) 322-8481	REPORTING UNIT CODE 1100
HEADQUARTERS ADDRESS (STREET NUMBER, CITY STATE AND ZIP CODE) 1507 21st Street, Suite 210, Sacramento, CA 95811			
SERVICE PROVIDER'S NAME		SOCIAL SECURITY NUMBER	
RESIDENCE ADDRESS (STREET NUMBER, CITY, STATE AND ZIP CODE			

DATE	TYPE OF SERVICE RENDERED (See Examples Below)	LOCATION (Where Expenses Were Incurred)	NUMBER OF HOURS	HOURLY RATE	$ AMOUNT
			TOTAL AMOUNT		

TYPES OF SERVICES PROVIDED:
Child Care Services
Interpreting Services
Reading Services
Driver Services
Assistant Services (Performs note taking services and general aids to daily living)
Facilitation Services (Provides assistance in understanding materials and participation)

CERTIFICATION

I hereby certify that the services itemized on the foregoing statement were actually received, and were essential to the performance of my duties.

SIGNATURE OF MEMBER

I hereby certify that the above member's statement is true and correct

SIGNATURE OF SERVICE PROVIDER

SIGNATURE OF OFFICER APPROVING PAYMENT